BRAND NAME MEDICATION
SCHEDULE II ANALGESIC CONTROLLED SUBSTANCE

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Requested medication_____

All information to be legible, complete and correct or form will be returned

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NOTE: Prior authorizations for brand name medications in this drug class require physician evaluated, charted documentation of an allergic reaction or adverse reaction. Patient complaints of lack of efficacy are not acceptable reasons for failure such as "Client said", "client reports", "doesn't work"or "causes nausea."

CRITERIA:_____

Documentation from **progress notes** detailing patient's allergic skin eruption or adverse reaction

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician or pharmacy